No. 95-17

(3)

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1995

STEVEN C. SCHUELLER, M.D.,

Petitioner,

vs.

ASHLEY MEMORIAL HOSPITAL; DR. T. BIRRIEL; DR. F.N. BURT; DR. E.A. GRESHAM; DR. L.F. GARCIA; DR. J.D. RANKIN; Estate of DR. C.E. RIPLEY, BETTY RIPLEY, Personal Representative; DR. D.L. TOON and DR. B.J. WALSH,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

REPLY BRIEF FOR PETITIONER

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Petitioner submits this brief in reply to respondents' brief in opposition to petitioner's Petition for a Writ of Certiorari.

FURTHER REASONS FOR GRANTING THE WRIT

I. THE LOWER COURTS IMPOSED A PRODUCT MARKET STANDARD UPON PETITIONER IN A § 1 RULE OF REASON ANALYSIS THAT CONFLICTS WITH A DECISION OF THIS COURT; TWO NINTH CIRCUIT DECISIONS; AND AN EIGHTH CIRCUIT DECISION, INVOLVING A SIMILAR CLAIM; HAS NO JUDICIAL OR EVIDENTIARY SUPPORT; AND IS UNSUPPORTED BY ANY ECONOMIC ANALYSIS.

A. Referrals as a Product Market

Respondents nowhere dispute the proposition that an antitrust plaintiff establishes a relevant market under *Eastman Kodak* by inquiring into the commercial realities faced by consumers. *Eastman Kodak Company v. Image Technical Services,* 112 S. Ct. 2072, 2090 (1992). Respondents advance no evidence, and cite no legal authority, in support of the lower courts' determination that consumers seek "medical referrals" separately and distinctly from the consumer's pursuit of medical services at time of need. *See Jefferson Parrish Hospital District No. 2 v. Hyde,* 104 S. Ct. 1561, 1562 (1984) (The test for presence of two separate products in alleged tying arrangements depends upon the character of the demand for the items).

There is no evidence that the commercial reality of any medical market compels a consumer to purchase a medical referral separately and distinctly from the consumer's purchase of the product itself — medical services at time of need. The commercial reality is that the consumer treats the "referral" as either part of the product itself — surgical services, in this case —

or as nothing more than a mechanism through which a medical market operates to deliver the product to the consumer.

The lower courts' legal conclusion that petitioner was required to prove an anti-trust injury to competition by focusing upon a product market in referrals subject Petitioner to a legal standard to which no other anti-trust plaintiff has been held.

B. Anti-Competitive Effect

The issue of national, over-riding, importance, to petitioner, is, can an agreement among physicians to collectively alter their referral patterns *ever* satisfy the injury to competition requirement under the rule? (Resp. Br., 4).

The Eighth Circuit concluded that, ". . . there is no market for referrals, [and found] that even if true, a reduced number of referrals is not evidence of anti-competitive behavior which violates federal antitrust laws. . . . Thus, the court finds no evidence of actionable anticompetitive conduct." (Pet. App. C, 5a).

The Eighth Circuit's unfounded assumption that an agreement, to alter referral patterns among a hospital and physicians, is harmless — despite evidence of the agreement's effect upon both output and price of the product — is totally inconsistent with this Court's prior decisions. *Federal Trade Commission v. Superior Court Trial Lawyers Assoc.*, 493 U.S. 411, 436 (1990).

The Eighth Circuit effectively concluded that, as *a matter of law*, an agreement among respondent physicians and a hospital that six primary care physicians — all of whom admit that they do not offer the product (surgical services) to consumers in this

market[1] (*see* Resp. Br. at 7-8, ". . . They were not surgeons who could provide those services. . .") — to the effect that the primary care physicians would alter their patient referral patterns, can *never* constitute anti-competitive conduct. In other words, and as a matter of law, no agreement among physicians and a hospital to collectively alter their individual referral patterns of physicians in any geographic market in this country, can constitute anti-competitive behavior, despite this Court's holding in *Eastman Kodak* — rule of reason analysis mandates an inquiry into the commercial realities faced by consumers[2] —and the presence of

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1. Four of five performed low-risk surgical procedures at respondent hospital (Pet. App. G, 84a & 104a-105a), and two respondent doctors, who had a joint medical practice, performed 90% of the caesarean section surgery at respondent hospital (Pet. App. G, 89a-90a).

2. *Eastman Kodak Company v. Image Technical Services,* 112 S. Ct. 2072, 2090 (1992).

Respondents pose very logical questions, suggesting that respondent primary care physicians do not harm competition unless they derive a direct economic benefit from the fruit of the agreement, and respondent hospital had no motive to enter an agreement to reduce surgical services, which facially appears detrimental to respondent hospital's economic interest. (Resp. Br. 7-8).

Three problems exist with respondents' queries.

First, *Kodak* holds that the commercial realities faced by consumers in the market determine injury to competition — not economic benefits gained by participants in a conspiracy.

Second, the questions attempt to meld two separate elements of petitioner's case into one- conspiracy and injury to competition. Respondent's filed no motion challenging petitioner's ability to satisfy the conspiracy element of his case outside the professional review process. (Pet. App. G, 80a-81a). Those questions are, as indicated, perfectly logical questions, assuming the issue was whether plaintiff was attempting to employ indirect evidence of respondents' substantially parallel conduct to establish the conspiracy element of his case. *See Matsushita Electric Industrial Co., Ltd. v. Zenith Radio Corp.* 475 U.S. 574, 596 (1986) (Rational economic motive broadens the range of permissible inferences that may be drawn from circumstantial evidence); (Cont'd)

(Cont'd)
Kodak, at 2083 (*Matsushita* requires the non-moving party' inferences be reasonable to withstand summary judgment).

Third, petitioner tendered, among other evidence, indirect evidence indicating all respondents possessed an economic motive to conspire against him, and all inferences suggested were reasonable.

In April 1986, respondent hospital convened a crisis meeting, attended by petitioner and respondent primary care physicians, at which respondent hospital threatened to close its doors within four months unless drastic measures were implemented, citing monthly financial losses of $29,000-30,000 (App. H, 164a). Closing the hospital would cost each physician a substantial portion of their incomes (*id.* at 163a-164a, 177a-179a).

All proposals discussed adversely affected each respondent primary care physician economically, except closing the surgery department (App. H, 165a-166a). There was evidence that respondent hospital never operated its surgery department profitably, despite a substantial increase in the number of surgical cases performed (App. H, 180a-181a). Petitioner's surgical referrals from respondent primary care physicians begin to decrease following this meeting.

The idea that there was no economic benefit to respondents from their conspiracy is absolutely preposterous.

The one thing each respondent primary care physician could do to help respondent hospital, without financially hurting themselves, was assist respondent hospital in reducing losses from its surgical department.

Respondent hospital's motive to join the agreement is obvious — reduce its losses. Respondent hospital transferred its surgical operating inefficiencies to other health care providers, between 1986 and 1989; and when surgical services were restored in 1989, respondent hospital enjoyed the economic benefits of collecting unwarranted fees and charges in a single surgical procedure that accounted for as much as 30% of total surgical output in this market.

Other evidence indicated that "[t]he plan [was] to let [petitioner] die on the vine and bring in another surgeon. . . ." (Pet. App. G,156a-158a). Another interesting question is where, in the face of respondent hospital's alleged self-interest in maintaining the level of surgical output, is the evidence of the steps which respondent hospital took between 1986 and 1989 to stem the tide of decrease in the number of surgeries performed?

evidence in this case indicating actual injury to competition.[3]

Respondents and the Eighth Circuit baldly posit that the *nature* of the agreement among respondents — an agreement that physicians will alter their individual referral patterns — is more important than the *effect* of this agreement upon output or price; and by subjecting petitioner to a standard to which no other litigant has ever been held, conclude that such an agreement can never be injurious to competition, despite evidence that the economic effect of the agreement to alter these referral patterns deprived half of the consumers in this market any access to the product whatsoever; and when the product was available, forced consumers of a substantial volume of the product to pay a higher price to obtain the product. Prior to 1989, 50% of the potential consumers in this market had no access whatsoever to the product as a result of this agreement.[4] Subsequent to 1989, and as a result of this agreement, a price conscious consumer of the single surgical procedure, accounting for as much as 30% of the total

3. This record is not the *Visa* case, *SCFC ILC, Inc. v. Visa USA, Inc., et al.*, 36 F.3d 958 (10th Cir. 1994), *cert. denied* __ U.S. __ (19__). In *Visa*, the joint venture which issued the credit cards had a by-law excluding from membership those who issued competing credit cards. The *Visa* plaintiff focused his claim almost entirely upon the power of the members of a joint venture to make rules governing membership, to which the Tenth Circuit replied that " . . . rule making power *per se* is not the focus of the market power analysis, but the effect of those rules — whether they increase price [or] reduce output. . . . *Visa*, 36 F.3d at 968.

Neither lower court concluded that the evidence petitioner offered was insufficient to establish actual harm to competition; rather, both lower courts concluded that an agreement to modify referral patterns can never, as a matter of law, produce an injury to competition (Pet. App. C, 5a).

4. Four of six respondent primary care physicians had a patient base equal to 50% of the potential consumers of surgical services in this market (Pet. 3, n.1; 5 & n.4 and accompanying text). There is no evidence that other suppliers of the product were present in the market, or that consumers could substitute some other product for surgical services.

surgical output in the market, was foreclosed from choosing the least expensive, yet adequate, treatment suitable for their needs (Pet. 5-6 & n. 5).

Both lower courts denied that the same agreement can have different economic effects in different markets.

An agreement to boycott a single physician, through an agreement to modify referral patterns, may have no adverse economic effect whatsoever upon the price or supply of the product the boycotted physician provides in a geographic market that is characterized by the presence of numerous providers of the same product or providers of different products which consumers view as inter-changeable.[5] In such a market, an affected physician will almost *never* satisfy the injury to competition requirement.

Yet, the same agreement to modify referral patterns, may have a substantial adverse effect upon the supply or price of a product in another geographic market that is characterized by a sole, or predominant, provider of a product, and in the absence of evidence that consumers view some other product available in this market as reasonably inter-changeable.[6]

This, petitioner submits, is nothing more than the factual dichotomy that exists under the current standards relating to rule of reason analysis.

Further, petitioner believes this record to be the ideal vehicle through which to test this legal concept. There is no dispute regarding existence of an agreement among respondents that the

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5. *Cf., Flegel v. Christian Hospital, Northeast-Northwest*, 4 F.3d 682 (8th Cir. 1993) and *Morgan, Strand, Wheeler & Biggs, et al. v. Radiology, Ltd., et al.*, 924 F.2d 1484 (9th Cir. 1990).

6. *See generally*, Pet. 12-17 & n. 17.

primary care physicians would alter their referral patterns or the scope of the geographic market; and the record contains evidence of actual injury to competition under a traditional rule of reason analysis.

Moreover, one published DHS report indicates that there are approximately 3,500 hospitals included within the category encompassing respondent hospital (99 beds and under). *Health United States 1994*, U.S. Department of Health and Human Services [DHS Pub. No. (PHS) 95-1232] (1994). Many hospitals in that category undoubtedly serve geographic markets which have characteristics similar to this market (*e.g.*, size, location, number of alternate providers). Another report indicates that more than 53,000 board certifications were extended to physicians during a ten year period covered by the report. *The Official ABMS Directory of Board Certified Medical Specialists 1995*, 27th ed. (1995) p. lv. Many of those board certified physicians, practicing in fields other than primary care medicine, depend entirely upon the referral process to deliver their product to the patient, as the ultimate consumer.

It is not unreasonable, in petitioner's view, to conclude that a substantial number of these board certified specialists hold staff privileges at hospitals similar in size and location to respondent hospital and serve geographic markets similar in size to the one described by this record.

Thus, petitioner believes that, not only is his case the proper vehicle to test the legal issues raised because of proper evidentiary development; but the legal issue has the potential to affect a substantial number of hospitals, other physicians, and consumers as well.

II. THIS IS AN ISSUE OF FIRST IMPRESSION RELATING TO THE ROLE WHICH A *PRIMA FACIE* § 1 CASE, BASED UPON ACTS TRANSPIRING OUTSIDE THE PROFESSIONAL REVIEW PROCESS, HAS UPON THE PRESUMPTION OF EFFICACY CONFERRED UPON PROFESSIONAL REVIEW WHEN THE REVIEW IS CONDUCTED BY THE SAME PARTIES AGAINST WHOM THE § 1 CLAIM IS HELD; THERE IS NO OBJECTIVE EVIDENCE AGAINST THE AFFECTED PHYSICIAN; AND IT IS ADMITTED THAT THE AFFECTED PHYSICIAN IS COMPETENT.

To date, no lower court has placed professional review in its proper context in petitioner's case. Petitioner sought to take the professional review action to the jury as an additional act of conspiracy against one or all defendants[7] and as evidence of permanent injury to his medical practice.

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7. Some cases attempt to employ the professional or peer review action to satisfy the combination or conspiracy element of their §1 claim. *See Weiss v. York Hospital*, 745 F.2d 786 (3rd Cir. 1984), *cert. denied*, 470 U.S.1060 (1985); *Nurse Midwifery Associates v. Hibbett*, 918 F.2d 605 (6th Cir 1990); *Bolt v. Halifax Hospital, Medical Center*, 851 F.2d 1273 (11th Cir. 1988), *vacated*, 861 F.2d 1283 (11th Cir 1988), *reinstated in part*, 874 F.2d 755 (11th Cir. 1989); *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1988). *See also, Willman v. Heartland Hospital East*, 34 F.3d 605, 612 (8th Cir. 1994) (Hospital staff physicians can conspire among themselves pursuant to an unlawful objective). Petitioner employed professional review as an additional act of conspiracy with concomitant injury.

The act may be the unilateral act of respondent hospital, or it may be the collective act of all respondents. *See* Pet. App. E, 38a-45a for the district court's discussion of the *Copperweld* doctrine and these cases. In the face of unchallenged allegations of continuing conspiracy *outside*, the professional review process (Pet. App. G, 80a-81a) the professional review action initiated against petitioner is admissible, as an act of conspiracy, against one or all parties.

Petitioner sought to accomplish these purposes by presenting evidence that (a) petitioner held a *prima facie* § 1 claim against respondents, based upon acts unrelated to the professional review process; (b) there is some evidence that petitioner and the participating physicians competed with each other in certain lines of business; (c) the hearing transcript reflects that no witness or other objective information was offered; and (d) there is evidence of professional competency.[8]

How did petitioner's case go awry? Petitioner lost the professional review issue because the lower courts applied an erroneous legal standard to extinguish petitioner's § 1 claim that was based upon evidence of acts transpiring entirely outside the professional review process. Extinction of petitioner's claim outside professional review totally deprived petitioner of the cumulative evidentiary value of all reasonable inferences that could be drawn from the facts described in subparagraphs (a), through (c) and (d), above.[9] *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986).

The legal issues here are, what evidence is sufficient to overcome the § 11112(a) presumption; what evidence is sufficient to sustain a jury verdict under § 111151(9)? There is no serious question here that the lower court's erroneous disposition of petitioner's § 1 claim, based upon evidence of actions occurring outside professional review, effectively precluded either lower court from properly reviewing this issue under the applicable summary judgment standard.

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8. *See* Pet. 19-21 & nn. 21-24.

9. Respondents nowhere contend that this evidence is insufficient to overcome the § 11112(a) presumption that the action was undertaken in the reasonable belief that it furthered quality health care, or to sustain a jury verdict in petitioner's favor under § 111151(9) that the action was primarily based upon some matter unrelated to petitioner's professional competence or conduct. (Opp. Br. 9-14). Likewise, there is no contention that petitioner received all reasonable inferences that can be drawn from this evidence. (*Id.*)

CONCLUSION

Petitioner believes that he has demonstrated both the importance, and the potentially wide-spread effect, of the issues involved. Petitioner believes that the Court should agree to consider these issues for the reasons set forth herein and in his original petition.

Respectfully submitted,

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PUBLISHER'S NOTE:

ORIGINAL PAGINATION IS NOT CONTINUOUS.

APPENDIX H — MISCELLANEOUS TRANSCRIPTS OF PROCEEDINGS

Joint Conference/Medical Staff Meeting Tuesday, April 1, 1986

JOINT CONFERENCE/MEDICAL STAFF MEETING
Tuesday, April 1, 1986

Attendance:

Richard S. Jones, Jr.
Herman L. Hamilton, Jr.
Edward L. Holt
C.E. Ripley, M.D.
B.J. Walsh, M.D.
D.L. Toon, M.D.
F.N. Burt, M.D.
W.R. Cothern, M.D.
Luis F. Garcia, M.D.
E.A. Gresham, M.D.
C.E. Hicks, M.D.
J.D. Rankin, M.D.
R.L. Salb, M.D.
S.C. Schueller, M.D.
Barry V. Thompson, M.D.
W.H. Schultz, M.D.

Also attending: Fred H. Smith, President, Warner Brown Services, Inc.
Phillip K. Gilmore, Vice President, Warner Brown Services, Inc.
Robert Kay, Treasurer, Warner Brown Services, Inc.
Norman K. Reynolds, Administrator, Ashley Memorial Hospital
J. Mike Ogden, Controller, Ashley Memorial Hospital

I. Call to Order.

Mr. Jones, Chairman-Joint Conference Committee, called the

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meeting to order at 6:00 p.m. April 1, 1986 in the First National Bank Board Room.

II. A.M.H. Financial Situation, Census and Future

Mr. Jones opened the meeting stating that the purpose is to inform the whole medical staff of the hospital's current financial status, the effect on the hospital and the effect on the physicians individual practices. He noted that the current financial situation is precarious and if the hospital were to close it would have an effect on the physicians as a substantial portion of their practice is conducted in the hospital. Without the hospital, their incomes will drop off substantially.

Dr. Ripley, Chief of Staff, said the purpose of the meeting is an effort to enlighten the physicians, receive their questions, and possibly get some answers. He felt that the medical staff needs to be aware of what it can do to correct the situation while understanding also that administration has an obligation to contain operating costs. He continued noting that changes in reimbursement by insurance companies and the federal government are requiring changes in medical practice patterns. He said that it is difficult to change the method of practice, however, it is vitally necessary.

Mr. Smith presented an overview of what has occurred nationally and how it is affecting Ashley Memorial. He noted there are many new regulations from Medicare regarding the payment of the physician and the hospital, there have been drastic changes in these payment methods, Ashley Memorial's occupancy has declined 11% while the number of Medicare patients has remained relatively stable. Therefore, as a percentage of total

occupancy, the amount of Medicare occupancy has risen. For the past several months the hospital has averaged a deficit or loss of approximately $29,000-$30,000 per month.

Assuming that everything remains as it currently is, that physician practice patterns are not modified, that the census remains in its present slightly downward curve, then it is projected that the hospital will run out of cash in August '86. This could mean closing the hospital.

He mentioned a number of options that have been considered recently, none of which appear to have long range value. HMO/PPOs have been looked at. Nationally the interest in this type organization seems to be cooling off. Additionally, this type organization will not fit Crossett as there are an insufficient number of people to enroll in such an organization.

With the increasing census of Medicare patients and the decreasing census of non-medicare patients, the hospital needs the physicians' help if it is to remain open and/or their suggestions on what to do if the hospital should be closed.

A number of quick fixes have been considered such as a self-insured health insurance program that could possibly be sold to employers with less than twenty-five employees. However, this appears to be very risky. Another quick fix might be a discount offered to G-P employees on the insurance deductible through the hospital foundation. This looks good and might be worth further consideration. Another option would be to have physicians covering the emergency room do separate billing rather than the hospital paying them. Another option is to cancel Warner Brown Management Services, also to be considered is possibly an elderly care program in conjunction with Meredith House and

reduce the hospital to one nursing unit. Another option that could possibly be considered would be closing the obstetrical unit and the recuperative care unit.

He then reviewed briefly the many positive changes that have been accomplished by Warner Brown Management Services over the past four years. He also noted that WBS has not been successful in several areas such as reducing supply costs, ICU/ CCU expenses, liability insurance, radiology expenses or surgical operating expenses.

He then suggested that to be considered would be a strong utilization review program with a paid physician to head it up and efforts to halt the outward migration of hospital patients from Crossett. He then emphasized that the physicians help is needed in these matters. He noted that the hospital has no capital reserves to pay for a new building.

With Mr. Ogden's assistance, Mr. Smith then reviewed in detail the hospital's recent financial history and the immediate future financial projections. He emphasized that Medicare is paying less and less and that additional cuts in Medicare reimbursement are projected for this fall. The hospital does need the physicians help in keeping the DRG losses down to within controllable limits. Again, he emphasized that the financial projection is only through August because at that point in time it appears the hospital will run out of cash if there are no changes in the admission patterns and physician practice patterns.

Mr. Hamilton, Chairman of the Board, pointed out that Ashley Memorial, as we have all known it, is a thing of the past. The hospital is a place for the physicians to practice his profession and it is now in jeopardy. In view of the situation, he said some

unpleasant prospects must be considered. Among these were such items as closing the OB unit, closing the emergency room, stop providing surgical service, etc. He suggested that the physicians give consideration to transferring patients when it is medically possible, so that we may decrease our losses on patients with no insurance.

General discussion of the situation ensued and many ideas and suggestions were broached. Among other things was suggested that the hospital should attempt to increase occupancy by recruiting full time specialists to Crossett. These would include specialists in orthopedics, pediatrics and urology.

It was noted that the Laboratory is sending a major portion of the lab work to Monroe. The lab situation was discussed in some detail noting that efforts are being made to improve that situation.

Dr. Toon reported that he had talked to Mayor Black regarding ambulance service and that the mayor had indicated that the city would be willing to provide ambulance services for the no insurance patient when it is necessary to transfer them if the hospital would underwrite 50% of the ambulance charge and provide a nurse to accompany the patient. This was discussed at some length with most of those present stating that this should be further investigated.

Mr. Hamilton asked what the staff was willing to do to improve the situation at A.M.H. He stated the "hot spot" at this time is the decline in non-medicare patients. The apparent immediate solution would be that the physicians must appreciate that the PRO game must be played and that efforts must be made to increase the non-medicare patient load. It was suggested that much more attention should be paid to public relations efforts in

this regard. Mr. Holt noted that PR is not just about the hospital, but it's also the physicians and their relations with the community. Dr. Toon agreed stating that PR must be a joint effort between the hospital and physicians.

Mr. Smith said that one of the gravest errors that he has noticed at A.M.H. is the apparent mistrust between the various groups. He stated this needs to be corrected, that all groups — the hospital board, the physicians, Warner Brown Services — must all work together in a cooperative progressive manner.

It was also recommended that organizations such as Arkansas First Mobile Diagnostic Services renegotiate their contracts so that they have a greater participation in the financial risks of non-paying patients. Greater attention must be paid to the question of admitting the Medicaid or no insurance patient for treatment. These admissions should be carefully screened and only admitted if there is a actual medical emergency. Among other ideas and topics it was pointed out that we need to recognize the following problems and opportunities:

1) If no preliminary diagnosis is known, admit for observation

2) Strong decision maker must be gatekeeper for hospital and doctors in E.R.

3) Encourage more G-P insurers to use A.M.H. Doctors must "sell" the idea that most things can be done here.

4) Include G-P in trying to get loggers to have adequate coverage for their log cutters and drivers.

Appendix H

5) Give an estimate to people prior to admission for typical hospital bill for each type admission — need price list.

6) Use Medicaid emergency room treatment criteria.

7) Stop any employee of A.M.H. from "putting down" hospital. Grounds for dismissal if employed by A.M.H.; loyalty deserved.

8) Instead of cutting back services, increase services and increase revenues.

It was further concluded that there are four topics that need priority attention. These are:

1) Improve/solve the laboratory situation

2) A solid joint public relations effort between hospital & physicians

3) Improve DRG performance

4) Increase census

Appendix H

Cover Page and Page 4 From Deposition of Dr. Garcia

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
EL DORADO DIVISION

NO. 92-1075

STEVEN C. SCHUELLER, M.D.,

PLAINTIFF

VS.

CLAIR NORMAN, HERMAN HAMILTON, JR., WILLIAM S. ARNOLD, NED HASTINGS, and ROOSEVELT EARLY, TRUSTEES OF THE CROSSETT HEALTH FOUNDATION; ASHLEY MEMORIAL HOSPITAL; DR. TOMAS BIRRIEL; DR. F.N. BURT; DR. E.A. GRESHAM; DR. LUIS F. GARCIA; DR. C.E. RIPLEY; DR. J.D. RANKIN; DR. D.L. TOON; DR. BENJAMIN J. WALSH; JOHN DOE #1; AND JOHN DOE #2

DEFENDANTS

DEPOSITION OF

LUIS GARCIA, M.D.

Appendix H

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Crossett, Arkansas
January 4, 1994

* * *

[4] PROCEEDINGS

Whereupon,

LUIS F. GARCIA, M.D.

having been called for examination, and having been first duly sworn, was examined and testified as follows:

Appendix H

DIRECT EXAMINATION

BY MR. WELCH:

Q What is your name, please.

A Luis F. Garcia.

Q What is your calling or profession?

A M.D. General Practitioner.

Q What is your office address?

A 306 Alabama.

Q Are your board certified in any specialty?

A No. General Practitioner.

Q Have you ever sat for any boards?

A No.

Q You are on staff at Ashley Memorial Hospital?

A Yes, I am.

Q Are you on staff at any other hospitals?

A No.

Appendix H

Q Do you hold any courtesy staff appointments?

A Not at present.

Q Have you held any other staff appointments on any other

* * *

Appendix H

Cover Page and Page 25 of Dr. Burt's Deposition

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
EL DORADO DIVISION

NO. 92-1075

STEVEN C. SCHUELLER, M.D.,

PLAINTIFF

VS.

CLAIR NORMAN, HERMAN HAMILTON, JR., WILLIAM S. ARNOLD, NED HASTINGS, and ROOSEVELT EARLY, TRUSTEES OF THE CROSSETT HEALTH FOUNDATION; ASHLEY MEMORIAL HOSPITAL; DR. TOMAS BIRRIEL; DR. F.N. BURT; DR. E.A. GRESHAM; DR. LUIS F. GARCIA; DR. C.E. RIPLEY; DR. J.D. RANKIN; DR. D.L. TOON; DR. BENJAMIN J. WALSH; JOHN DOE #1; AND JOHN DOE #2

DEFENDANTS

DEPOSITION OF

FREDERICK N. BURT, M.D.

Appendix H

APPEARANCES:

On Behalf of Plaintiff:

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Crossett, Arkansas
January 4, 1994

* * *

[25] then that's who it was.

Q Do you know who Herman Hamilton is?

A Yes.

Q What was his position?

A He was probably Chairman of the Board at that time. I'm not sure. He has been Chairman of the Board.

Q The Minute quotes Mr. Jones as opening the meeting and saying if the hospital were to close —

Appendix H

A I remember a Mr. Jones. Yes, he's dead now. I remember who it is.

Q It says if the hospital were to close it would have an effect on the physicians as a substantial portion of their practice is conducted in the hospital. Without the hospital, their incomes would drop off substantially. Would you agree with that statement?

A Yeah, I would agree with it.

Q So long as you're in Ashley County would you say that your income is tied directly to the fortune of the hospital?

A Yes.

Q This Minute discusses many new regulations for Medicare concerning the payment of physicians and the hospital, changes in the payment methods and that the hospital's occupancy rate was going down but the number of Medicare patients had remained the same and that the hospital was losing $29,000 to $30,000 a month. Do you remember some discussion at some

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Appendix H

DRG Committee Meeting

DRG Committee Meeting

PRESENT: C.E. Ripley, M.D., Chairman
E.A. Gresham, M.D.
D.L. Toon, M.D.
J. Jeffrees, R.N., DRG Co-Ordinator
N. Reynolds, Administrator

I. Call to Order.

Dr. Ripley, Chairman, called the meeting to order at 12 o'clock Noon November 1, 1984 in the Board Room of A.M.H.

II. DRG Performance Review.

The Committee reviewed the year-to-date DRG report noting that through September 30, the hospital had incurred a "loss" of $6,419.00. By physician the profit and loss varied from a profit of $29,000 for one physician down to a loss of $20,345 for another physician.

It was suggested that monthly each physician should receive the DRG print out on each of his medicare patients plus the usual monthly DRG report of all physicians. In addition, the monthly summary of all physicians is to be distributed and discussed at the Medical Staff meeting.

The Chairman requested that the DRG Co-Ordinator prepare a report showing the average ancillary charges created by each physician for the third quarter of 1984. This is to be presented and discussed at the November Medical Staff meeting.

Appendix H

The Committee noted that at present, the hospital appears to be losing money on all medicare surgical procedures. This is due primarily to the hospital's reimbursement rate being based on the year 1982 when there was very little surgery being performed. It was suggested that the possibility of the hospital's reimbursementary being revised to reflect the current surgical load be investigated.

There was general discussion of the use of non-specific diagnoses versus specific diagnoses. It was noted that the rules are now changed regarding just what a specific diagnosis is. Previous to 1984 a diagnosis such as "Peptic Ulcer Disease" was considered adequately specific, however, under the DRG rules that diagnosis is non-specific. It was recommended that all members of the Medical Staff be made aware of this continuing problem and that all be encouraged to use the diagnosis work sheet so that the DRG Co-Ordinator can develop a proper and specific diagnosis for each particular patient.

III. Adjournment.

There being no further business to come before the Committee, the meeting was adjourned.

s/ C.E. Ripley
C.E. Ripley, M.D., Chairman